INSURANCE
NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program

Proposed Amendments: N.J.A.C. 11:21-3.2, 4.1, 4.4 and Appendix Exhibits A, F, G, N, O, V, W, Y, BB, HH and II.

Proposed Repeal: N.J.A.C. 1:21 Appendix Exhibits H, I, J, K, Z, AA and JJ.

Proposed New Forms: N.J.A.C. 11:21 Appendix Exhibits H, and K.

Authorized By: New Jersey Small Employer Health Benefits Program Board, Wardell Sanders, Executive Director.

Authority: N.J.S.A. 17B:27A-17 et seq.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2002-

Interested persons may testify at a public hearing to be held at 1:00 P.M. on Wednesday, March 20, 2002 at the New Jersey Department of Banking and Insurance, Room 218, 20 West State Street, Trenton, New Jersey.

Submit written comments by April 5, 2002 to:

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The agency proposal follows:

## Summary

### Authority for Changes

Pursuant to N.J.S.A. 17B:27A-7 and 17B:27A-11d, the New Jersey Small Employer Health Benefits ("SEH") Program Board has the responsibility to establish the standard health benefits plans used in the small employer market and the authority to modify the plans consistent with the requirements of the Board's enabling statute. As required by N.J.S.A. 17B:27A-16.1c, the Board has scheduled a public hearing to receive oral testimony regarding the proposed modifications, repeals and additions to the standard health benefits plans described herein, at the time and place noted above.

As permitted by N.J.S.A. 52:14B-3(4)(e), as amended by P.L. 2001, c.5, and N.J.A.C. 1:30-3.3, the New Jersey Small Employer Health Benefits Program Board ("SEH") Program Board has chosen to provide a 60-day comment period rather than provide notice of this proposed rule in a published, quarterly calendar of anticipated rulemaking. As the Board has provided a 60-day comment period for the proposal, the proposal is excepted from the rulemaking calendar requirements pursuant to N.J.A.C. 1:30-3.3(a)5.

The SEH Board proposes amendments to the standard small employer health benefits plans named A, B, C, D, E, HMO and HMO-POS, the employer Application, the small employer Certification of Compliance set forth as Exhibits A, F, G, N, O, V, W, Y, BB, HH and II of the Appendix to N.J.A.C. 11:21. As explained below, the SEH Board proposes to repeal the Prescription Drug riders currently set forth as Appendix Exhibits H, J, Z and AA and propose a single Prescription Drug rider, set forth at Appendix Exhibit H. As explained below, the SEH Board proposes the repeal of the Mental or Nervous Conditions Rider, Appendix Exhibit I, and part 4 of Appendix Exhibit Z. The SEH Board proposes to repeal the Explanation of Brackets exhibits, Exhibits K, and JJ

and delete the explanation of brackets text from Exhibit N. The SEH Board proposes a single document providing all explanations of brackets for all standard forms, set forth at Appendix Exhibit K.

The Board anticipates that the changes will be effective for plans issued or renewed on or after July 1, 2002.

Changes to Comply with New Jersey Law

To comply with the requirements of P.L. 1999, c. 395, the new Rider for Prescription Drug Insurance set forth at Appendix Exhibit H provides that the card/mail option provides coverage for up to a 90-day supply of drugs, whether the prescription is obtained from a mail order pharmacy or from a non-mail order pharmacy. In addition, consumers obtaining prescription drugs from a non-mail order pharmacy that have agreed to the same terms conditions, price and services as a mail order pharmacy will pay the same copayment as he or she would have paid had the prescription been filled by a mail order pharmacy.

To comply with the requirements of P.L. 1999, c. 341, the coverage for mammography contained in Plans A through E and the non-network component of the HMO-POS plan has been amended to provide for coverage for one mammogram examination every year for female covered persons age 40 and older.

To comply with the requirements of P.L. 2000, c.121, Plans B through E, HMO and HMO-POS have been amended to specifically provide coverage for the treatment of hemophilia.

To comply with the requirements of N.J.A.C. 18:38, the regulation that addresses various requirements of the Health Care Quality Act, Plans A through E, HMO and

HMO-POS have been amended to include definitions of terms consistent with those contained in N.J.A.C. 18:38 and to provide the notices and disclosures required by N.J.A.C. 18:38.

To comply with the requirements of P.L. 1999, c.383, the exclusion related to work-related injuries or illnesses contained in Plans A thought E, HMO, HMO-POS and in the prescription drug rider has been amended to state that the standard plan will provide coverage for a work-related injury or illness when the self-employed persons described in the law elect not to purchase Worker's Compensation coverage.

To comply with the requirements of N.J.A.C. 11:4-42.8(a)3, the penalty for failure to secure pre-approval as contained in plans A through E and HMO-POS has been amended to provide for a fifty percent reduction in benefits.

The ERISA Claims Procedure text has been revised to reduce the period of time in which to pay claims from 45 days to 30 days, consistent with New Jersey Prompt Pay requirements found at N.J.S.A. 17B:30-26-34 and N.J.A.C. 11:22-1.1.

To comply with the Supreme Court opinion in the case of Maria Perreira and Luciano Perreira v. Michael C. Rediger et als., 169 N.J. 399 (2001), and the Department of Banking and Insurance Bulletin No. 01-11, the Right to Recovery-Third Party Liability provision contained in Plans A through E, HMO and HMO-POS has been deleted.

Changes to Address Federal Law

The benefits for reconstructive breast surgery in Plans A through E, HMO and HMO-POS have been clarified to specifically include text from the federal Women's Health and Cancer Rights Act. Specifically, the reconstructive breast surgery provision

has been amended to state that coverage is provided for the treatment of physical complications of mastectomy, including lymphedemas.

The Appeals Procedure in Plans A through E, HMO and HMO-POS include direction to carriers to include text that addresses the claims procedure requirements under federal law set forth in 65 Fed. Reg. 70246, pages 70268 – 70271, (2000) to be codified at 29 CFR § 2560.

The ERISA text included in Plans A through E, HMO and HMO-POS has been revised to conform to the specimen text set forth in 65 Fed. Reg. 70226, page 70243, (2000) to be codified at 29 CFR § 2520.

The description of network providers in Plans A through E, HMO and HMO-POS has been expanded to advise covered persons that provider lists are furnished automatically, and provided without charge, as required by 65 Fed. Reg. 70226, page 70241, (2000) to be codified at 29 CFR § 2520.

The Continuation Rights provision in Plans A through E, HMO and HMO-POS has been amended to comply with recent amendments to the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Change to Accommodate the Coverage Described in the Consensus Document

In December 1999, a number of carriers participating in the New Jersey Working Group to Improve Outcomes in Cancer Patients voluntarily agreed to provide coverage to patients participating in scientifically valid cancer clinical trials. In order to accommodate those carriers that are participating in the Consensus Document, Plans B through E, HMO and HMO-POS include variable language that a carrier that signed the

Consensus Document may include in the standard plans to specify the nature of the coverage.

Other Modifications to the Standard Plans

- Schedule Page Text

The Coinsurance text provision of the Schedule in Plans A through E has been amended to clarify that coinsurance does not include either Cash Deductibles or Copayments.

The Coinsurance provision detailing coverage for Network and Non-Network coverage as applicable in PPO and POS plans issued using plans B through E and HMO-POS has been amended to state that coverage for prescription drugs is always covered subject to the Non-Network level of benefits. This change will eliminate confusion regarding whether the benefit is paid at the Network or Non-Network level based on the pharmacy where the prescription is filled or based on the provider who prescribed the prescription drug.

Text regarding referrals as found in POS plans issued using plans C through E and HMO-POS has been revised to clarify that Non-Network benefits are payable if a person fails to secure a referral regardless of whether the provider who provided the services is a Network or a Non-Network provider.

Optional schedule pages have been added to Plans B through E to allow split deductible and split coinsured charge limit calculations when the plan is issued as a PPO or a POS plan. Thus, carriers may structure plans in which the network deductible accumulates separately from the non-network deductible, and the network coinsured charge limit accumulates separately from the non-network coinsured charge limit.

The list of services and supplies in Plans B through E for which pre-approval may be required has been expanded to include speech, cognitive rehabilitation, occupational and physical therapies and certain prescription drugs. Carriers that elect to require pre-approval in connection with these services would add such services to the list on the schedule page.

The limits applicable to private duty nursing and home health care have been added to the schedule page for plans B through E, HMO and HMO-POS.

The $1,000,000 lifetime benefit that was included for Plan B has been deleted and replaced with an unlimited lifetime benefit.

The premium rates provision of the schedules in plans A through E, HMO and HMO-POS have been amended to clarify that rate changes can only be made prospectively.

- General Provisions

The Statements provision in Plans A through E, HMO and HMO-POS has been revised to delete the reference to the beneficiary. Since health plans do not allow the designation of a beneficiary, the reference to a beneficiary was not necessary.

The Premium Amounts provision in Plans A through E, HMO and HMO-POS has been revised to delete the possibility of alternative methods for the calculation of premium payments.

An optional Reinstatement provision that addresses the acceptance of premium beyond the grace period and the impact on continued coverage has been added to Plans A through E, HMO and HMO-POS.

The Premium Rate Changes provision in Plans A through E, HMO and HMO-POS has been revised to state that premiums can only be changed prospectively, and to require carriers to give at least 45 days advance notice, increased from a 30-day notice period, of a change in rates to the policyholder.

The Clerical Error-Misstatements provision in Plans A through E, HMO and HMO-POS has been has been modified to delete the references to an amount of coverage. References to an amount of coverage would be appropriate in a life or disability plan, for example, but do not have significance in a health plan.

The Termination of the Policy/Contract Renewal Privilege provision in Plans A through E, HMO and HMO-POS has been re-named as Term of the Policy/Contract – Renewal Privilege – Termination. The text of the provision has been re-organized for clarity.

The Conformity with Law provision in Plans A through E, HMO and HMO-POS has been revised to clarify that the provision addresses both New Jersey law and Federal law.

- Claims Provisions

The Limitations of Actions provision in plans A through E has been deleted from the Claims Provisions since it appeared also in the General Provisions.

- Definitions

The following terms have been newly defined in Plans A through E, HMO and HMO-POS: Accredited School; Approved Cancer Clinical Trial (a definition a carrier would only include if the carrier elects to include the optional benefit description); Emergency; Private Duty Nursing; Referral; and Urgent Care.

The definitions of the following terms in Plans A through E, HMO and HMO-POS were revised for clarity: Actively at Work; Affiliated Company; Alcohol Abuse; Creditable Coverage; Custodial care; Dependent; Diagnostic Services; Experimental or Investigational; Facility; Illness; Injury; Nurse; Pre-Approval; Skilled Nursing Care; Skilled Nursing Facility (changed from Skilled Nursing Center); and Surgery.

The definitions of the following terms in Plans A through E, HMO and HMO-POS were deleted as the terms were not used: Current Procedural Terminology; Generic Drug; and Medical Emergency.

- Employee Coverage

The following clarifications were made in Plans A through E, HMO and HMO-POS: The Multiple Employment provision was amended to address earnings and the number of hours worked for affiliated companies; the When Employee Coverage Starts provision was amended to address the effective date of coverage for a late enrollee.

The Eligibility text of the HMO-POS plan was expanded to include variable text to address a requirement that employees reside in the service area.

- Dependent Coverage

The following clarifications were made in Plans A through E, HMO and HMO-POS: The Incapacitated Children provision was expanded to include the term developmentally disabled; the Enrollment requirement provision was amended to address the termination of the employer's contribution toward dependent coverage; the When Dependent Coverage Starts provision was clarified to address the effective date of coverage for a late enrollee; the Newborn Children provision was clarified to specify that coverage for the first 31 days is without additional premium and addresses the notice requirements; the

When Dependent Coverage Ends provision was expanded to include variable text to allow an end of the month termination of coverage.

The dependent eligibility text was expanded to include variable text that would allow a carrier to limit coverage only to dependents who reside in the service area.

- Benefit and Coverage Provisions

The Cash Deductible and Coinsured Charge Limit provisions in plans B through E was expanded to include variable text for a split deductible and split coinsured charge limit provisions.

The "If This Plan Replaces Another Plan" provision of plans A through D was amended to clarify that although deductible credit is given, no coinsurance credit is given. Thus, if a covered person had already satisfied the deductible and reached the coinsurance cap or coinsured charge limit, as applicable, the person is entitled to credit under the replacement plan for already having satisfied the deductible, but must resume coinsurance liability anew.

The "Home Health Care Charges" provision of Plans B through E, HMO and HMO-POS has been revised to include a 60-visit limit with respect to the nursing care services provided under a home health care plan. Since this change represents a reduction in benefits, all carriers are required to identify all persons currently receiving benefits for home health care. Those persons are to be afforded unlimited nursing care benefits, subject to medical necessity for as long as long as coverage under the employer's policy or contract is in force. The 60-visit limit may apply only prospectively to persons who first receive home health care benefits after the effective date of the

changes to the standard plans. In addition, some of the terms of the home health care benefit were clarified.

A new provision entitled Private Duty Nursing Care has been added to Plans A through E, HMO and HMO-POS. Under this benefit, coverage is provided for up to 360 hours of private duty nursing per year, subject to carrier pre-approval.

The Anesthetics and Other Services and Supplies provision of Plans B through E and HMO-POS has been amended to add coverage for medically necessary replacements of various supplies.

The Prescription Drugs provision of Plans B through E, HMO and HMO-POS has been amended to include variable text that carriers could include to impose a pre-approval requirement for certain drugs.

The prescription drug coverage in Plans B through E, HMO and HMO-POS has been amended to include text to state that coverage is provided for supplies which require a prescription that are essential to the administration of the prescription drug.

The Therapy Services provision in Plan B through E and the non-network therapy services benefit in the HMO-POS plan has been amended to include coverage for certain therapies as might be used for the treatment of a biologically-based mental illness. In addition, variable text allows Carrier to include a pre-approval requirement in connection with physical, occupational, speech and cognitive rehabilitation therapy services. The Therapy Services provision of the HMO plan and the network portion of the HMO-POS plan has been amended to replace the 60-day per incident of illness or injury limitation on services with a 30-visit benefit per calendar year and to mirror the amended benefit in the B through E plans.

The fertility benefits provision in Plans B through E, HMO and HMO-POS has been amended to specifically list the limited services and supplies the plans cover. Services and supplies that are not listed are not covered.

The Preventive Care provision of plans B though E, and the non-network section of the HMO-POS plan have been amended to include bone density testing as a service a person could select to use under the preventive care benefit.

The Vision Screening provision of Plans B though E, HMO and HMO-POS has been revised to clarify the limited nature of this coverage.

The Transplant Benefits provision of Plans B though E, HMO and HMO-POS has been amended to include coverage for intestine transplants. In addition, the provision has been amended to state that costs for the donor associated with the donation are covered if the donor is not covered under a plan that will provide coverage for the donation. The costs that will be covered do not include travel, accommodations or comfort items.

The Alternate Treatment Features provision of plans A though E and the non-network section of the HMO-POS plan has been re-named as Specialty Case Management. In addition, the re-named provision was clarified to explain that it is solely up to the carrier to determine whether Specialty Case Management should be considered.

The dental care exclusion of Plans A through E, HMO and HMO-POS has been amended to clarify that dental implants are not covered.

The eye surgery exclusion of Plans A through E, HMO and HMO-POS has been amended to state that lasik surgery is not covered.

The fertility exclusion of Plans A through E, HMO and HMO-POS has been clarified to specifically state that donor sperm and surrogate motherhood are not covered.

The exclusion for methadone maintenance in Plans A through E, HMO and HMO-POS has been deleted.

The exclusion for war was amended to delete the phrase concerning riots and insurrection.

The Continuation Rights and Medicare as Secondary Payor provisions which are based on federal law, as contained in Plans A through E, HMO and HMO-POS have been amended to include parenthetical statements giving very general guidance as to which size groups are subject to the various provisions of these provisions.

Changes to Ancillary Forms

- Employer Application

The form, as appears at Appendix Exhibit N, has been revised to specifically allow for electronic signatures, to ask a question about the application of the Medicare as Secondary Payor regulation to the group, and to ask about participation of a professional employer organization. These changes were made to assist carriers with underwriting and administering the small employer plans.

- Employer Certification

The text of the form, as appears at Appendix Exhibit O, has been reorganized and re-formatted to make it easier to complete.

- Prescription Drug Rider

The existing prescription drug riders found at Appendix Exhibits H, J, Z and AA were created in 1993, well before any of the new approaches to prescription drug coverage were developed. Rather than create riders for use with specific plans, the SEH Board proposes the use of a single rider with sufficient variable material to allow use with any

of the standard forms. This new rider is proposed as Appendix Exhibit H. In addition, the new rider for prescription drug coverage gives carriers the flexibility to include provisions to allow pre-approval of certain drugs, and the use of an open formulary. The rider, as proposed can be crafted to provide a card-only benefit, mail order benefit or a card/mail benefit.

- Mental or Nervous Condition Rider

The rider, found at Appendix Exhibits J and part 4 of Exhibit Z was developed in 1993 before managed mental health programs were widely used. Carriers did not find the rider, as developed, to meet their needs in terms of a managed mental health benefit. As a result no carriers elected to use the rider. Carriers can accomplish managed mental health coverage for network coverage using the managed care provisions included in the standard forms. Thus, the rider is unnecessary. The Board proposes the elimination of this standard rider.

- Certification of Compliance

Changes were made to the Certification of Compliance, Appendix Exhibit BB, Parts 1 and 2, to address the plan options proposed herein.

- Explanation of Brackets

The form, as proposed as Appendix Exhibit K, will consolidate all information concerning variable areas contained in the standard plans. The Explanation of Brackets was included on several documents, which are proposed for elimination in this proposal, namely, Exhibits K, JJ and the final page of Exhibit N.

Social Impact

The amendments to the standard small employer health benefits market were primarily designed by the Board to comply with State law. The Board recognizes that the addition of benefits to the standard plans may result in rate increases.

The amendments proposed herein also will affect the 40 carriers offering coverage in the small employer health benefits market. If the proposed changes are adopted, all carriers will be required to amend the standard plans. As a result of these changes, carriers also will be responsible for educating their employees and agents of the changes to the small employer health benefits plans and for assisting insureds or enrollees.

Economic Impact

The proposed amendments should have an economic impact on small employers and employees of small employers in that the addition of coverage for mandated benefits, as described above, will likely cause an increase in rates for coverage. Some of the increase may be mitigated by some of the cost containment features included herein. Such features include a limit on home health care nursing services, a limit on coverage for private duty nursing, and allowing carriers to use pre-approval and formularies for prescription drug coverage. Since carriers determine the rates, the Board cannot anticipate exactly how much the rates may increase.

Carriers will experience an economic impact as they will be required to print new policy forms and contracts as appropriate. Carriers also will have to disseminate information regarding these changes to their employees.

Federal Standards Statement

The standard small employer health benefits plans comply with the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191. The standard small employer health benefits plans comply with 29 CFR Parts 2520 and 2560. The standard small employer health benefits plans comply with the Newborns and Mother's Health Protection Act of 1998 and the Women's Health and Cancer Rights Act. The standard plans, and the rules describing the standard plans, do not expand upon the requirements set forth in the Federal law.

Jobs Impact

The proposed amendments are not expected to result in the generation or loss of jobs in the State if they were to take effect.

Agriculture Industry Impact

The proposed amendments have no impact on the agriculture industry.

Regulatory Flexibility Analysis

The Board believes that all carriers subject to these rules have in excess of 100 employees or are located outside of the State of New Jersey. Therefore, a regulatory flexibility analysis is not required. However, to the extent that any carrier might be considered a small business under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the following analysis would apply.

The proposed amendments to the standard plans will require carriers to amend their standard policy forms, and to conform their operations (sales, administration, and claims handling) to the new changes in the plans. There will be capital costs involved in such compliance, in terms of printing, systems programming, staff and agent training, etc., but it is unlikely that any carrier would have to contract for outside professional

services in order to comply. All of the required changes to a carrier's business fall within the normal functions a carrier performs in complying with any state insurance law or regulations. An exemption from the policy form changes for certain carriers that are small businesses would be inappropriate because such an exemption would permit the sale of non-conforming forms in an otherwise completely standardized market.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

11:21-3.2 Optional benefit riders to standard plans and administrative functions

(a) Members that offer health benefits Plans B, C, D and E may offer one or more of the standard optional benefit riders set forth in (c)1 and 2 below. Members that offer the HMO health benefits plan may offer the prescription drug riders set forth in (c)3 below. All riders shall contain the benefits, limitations and exclusions set forth in the Appendix which is incorporated herein by reference and shall be issued in the standard form set forth in the Appendix which is incorporated herein by reference. A member electing to offer an optional benefits rider with a standard health benefits plan (Plan B, C, D, E, or HMO plan, as applicable) must offer the rider to any employer seeking to purchase that health benefits plan.

(b) Any member electing to offer one or more standard optional benefits riders shall file a statement identifying the rider(s) to be offered and identifying the health benefits plan(s) with which the rider will be offered. The statement shall be filed with the Board no later than 30 days prior to the date the rider is to be offered to employers, and shall set forth the date on which the carrier proposes to offer such rider(s).

(c) The standard optional benefit riders are as follows:

1. Replacement prescription drug benefits for Plans B, C, D and E. The carrier may select [one or more of] the following rider[s], set forth at Exhibit H, to be offered with each health benefits Plan (Plan B, C, D or E):

i. [Exhibit H, part 1 (] mail order and card[)];

ii. [Exhibit H, part 2 (]card only[)]; or

iii. [Exhibit H, part 3 (]mail order only[)].

[2. Replacement mental and nervous conditions and substance abuse benefits, Exhibit I; and]

[3]2. Replacement prescription drug benefits for the HMO Plan or the HMO POS Plan. The carrier may select one or more of the following riders, set forth at Exhibit H, to be offered with the HMO or HMO POS health benefits plan:

i. [Exhibit J, part 1 (]mail order and card[)];

ii. [Exhibit J, part 2 (]card only[)]; or

iii. [Exhibit J, part 3 (]mail order only[)].

(d) In addition to the standard optional benefit riders listed in (c) above, members may offer riders that revise in any way the coverage offered by Plans A, B, C, D, E, HMO, and HMO POS plan subject to the provisions set forth in (d)1 through 8 below.

1. Before a member may sell a rider or amendment thereof that decreases any one benefit or decreases the actuarial value of Plans A, B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof for informational purposes with the Board, and for approval by the Commissioner. No rider filed with the Commissioner may be sold until approved by the Commissioner.

2. Before a member may sell a rider or amendment thereof that increases any benefits or increases the actuarial value of Plans A, B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof with the Board for informational purposes.

3. "Coverage" offered by the five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)2 above includes, but is not limited to:

i. The types and extent of services and supplies described in the "Covered Charges, " "Covered Charges with Special Limitations" and "Exclusions" sections of Plans A, B, C, D, and E the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan, and the "Covered Services and Supplies," "Covered Charges," "Covered Charges with Special Limitations," "Non-Covered Services and Supplies and Non-Covered Charges" sections of the HMO POS plan;

ii. Deductibles, Coinsurance, Copayments, Coinsured Charge Limits, and Coinsurance Caps of Plans A, B, C, D, E, HMO, and HMO POS as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first dollar coverage), and their applicability in situations involving common accident; and

iii. Eligibility as set forth in the "Employee coverage," "Dependent Coverage" and "continuation Rights" sections of Plans A, B, C, D, and E, the "Eligibility" and "Continuation Provisions" of sections of the HMO plan, and the "Eligibility" and "Continuation Rights" sections of the HMO POS plan.

4. “Coverage” offered by the five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)2 above does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of “health benefits plan” in N.J.A.C. 11:21-1.2, except for dental coverage where the additional dental coverage is subject to the standard plan’s deductible and coinsurance or copayment schedule, as applicable; or

iii. Benefits which are other than those provided under a “health benefits plan” as defined at N.J.A.C. 11:21-1.2.

5. In addition to (d)1, 2, 3, and 4 above, any benefit rider or amendments thereof shall be subject to the provisions of Sections 2, 3(b), 6, 7, 8, 9 and 11 of P.L. 1992, c.162.

6. A member making an informational filing to the Board pursuant to (d)2 above shall:

i. Submit an original and one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:21-1.3;

ii. Submit copies of the rider or riders which amend the standard group policy and certificate forms, which rider or riders shall include cross-references to the standard group policy and certificate provisions or sections and/or pages which are being modified;

iii. Specify whether the rider or amendment thereof is to be used in connection with standard health benefit Plans A, B, C, D, E, HMO, or HMO

POS plan and provide clear and conspicuous notice of such on the forms submitted for each rider;

iv. The standard group policy and employee certificate language shall not be altered, and the benefit modifications shall appear only on the rider or riders;

v. Submit copies of the standard group policy and certificate page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders; and

vi. For riders of increasing value only, submit copies of a certification signed by a duly authorized officer of the member that states clearly:

(1) That the rider or amendment thereof increases a benefit or benefits and does not include a decrease of any benefits or decrease in the actuarial value of standard health benefits Plan A, B, C, D, E, HMO, or HMO;

(2) That the filing is complete and in accordance with all the requirements of this subsection and applicable New Jersey statutes and regulations;

(3) That the member will offer the rider or amendment thereof to any small employer seeking to purchase the health benefits plan it modifies;

(4) That a rate filing has been made with the Commissioner pursuant to N.J.A.C. 11:21-9; and

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement or the

HMO POS contract, that the plan as ridered continues to comply with the requirements set forth in N.J.A.C. 11:4-37.3(b)6 and N.J.A.C. 8:38-14.4(c), as applicable.

7. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in substantial compliance with this subsection within 45 days of the Board's receipt of the member's submission of a rider or amendment thereof. If the Board does not notify a member of its determination with respect to an informational filing within 45 days of the date of submission thereof, the informational filing shall be deemed complete.

i. If an informational filing is incomplete, but in substantial compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing.

ii. If an informational filing is incomplete, and not in substantial compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing. Upon receipt of notice from the Board that a filing is incomplete and not in substantial compliance with the requirements of this subchapter, the member shall not sell the rider or amendment thereof until the member has received written notice from the Board that the informational filing is in substantial compliance or complete.

iii. If the Board takes no action within 45 days of receipt by the Board of a member's submission of information requested by the Board to complete an informational filing, the filing shall be deemed to be in substantial compliance.

(e) A carrier may provide for alternative means of administering aspects of the standard forms which administration does not affect the benefits provided in the standard policy forms and riders. Administration includes, but is not limited to, administration of claims, COBRA, premium collection, and issue functions. The delegation of administrative functions shall be achieved by a separate contract between the carrier and/or the small employer, and a third party. Such arrangements shall not alter the standard group policy and certificate language.

(f) All carriers shall file, by March 1 of each year, Exhibit BB Part 6, on which all optional benefit riders are identified, regardless of whether or not the carrier has filed optional benefit riders.

11:21-4.1 Policy forms

(a) Members shall use the standard policy forms for Plans A, B, C, D, and E which are set forth in the Appendix to this chapter as Exhibits A, F, V, and W subject to the "Explanation of Brackets" set forth in Exhibit K[, Part 1] of the Appendix, incorporated herein by reference. Members shall not make any changes to the text of the standard policy forms, except as permitted consistent with the explanation of brackets set forth as Exhibit[s] K [and JJ].

1. Notwithstanding (a) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

(b) Members shall use the standard policy form for HMO Plan which is set forth in the Appendix to this chapter as Exhibit G and Y, subject to the "Explanation of Brackets" set forth in Exhibit K[, Part 2] of the Appendix, incorporated herein by reference.

1. Notwithstanding (b) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq.,

apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

(c) Members shall use the standard policy form for HMO-POS plan which is set forth in the Appendix to this chapter as Exhibit HH and II, subject to the "Explanation of Brackets" set forth in Exhibit [JJ]K of the Appendix, incorporated herein by reference.

1. Notwithstanding (c) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

(d) In issuing standard optional benefit riders pursuant to N.J.A.C. 11:21-3.2(c), members shall use the standard rider form[s] which [are] is set forth in the Appendix to this chapter as Exhibit[s] H[, I, and J, as applicable].

(e) All health benefits plans and optional benefits riders issued to small employers on and after January 1, 1994 shall be issued in accordance with these rules.

(f) Members shall use the standard small group health benefits certificate for Plan A which is set forth in the Appendix to this chapter as Exhibit V, subject to the "Explanation of Brackets - Certificate Forms" set forth in Exhibit [X, Part 1]K of the Appendix, incorporated herein by reference.

(g) Members shall use the standard small group health benefits certificate for Plans B, C, D and E which is set forth in the Appendix to this chapter as Exhibit W, subject to the "Explanation of Brackets - Certificate Forms" set forth in Exhibit [X, Part 1]K of the Appendix, incorporated herein by reference.

(h) Members shall use the standard employee evidence of coverage for HMO Plan which is set forth in the Appendix to this chapter as Exhibit Y, subject to "Explanation of Brackets (HMO Plan)" set forth in Exhibit [X, Part 2]K of the Appendix, incorporated herein by reference.

(i) Members shall use the standard employee evidence of coverage for the HMO POS plan which is set forth in the Appendix to this chapter as Exhibit II, subject to "Explanation of Brackets (HMO/POS Plan)" set forth in Exhibit [JJ]K of the Appendix, incorporated herein by reference.

(j) [Members shall use the Rider - Certificate Forms for Plans B, C, D and E as set forth in the Appendix to this chapter as Exhibit Z, Part 1, "Card/Mail"; Part 2, "Card"; Part 3, "Mail"; and Part 4, "Mental and Nervous Conditions and Substance Abuse Benefits."

(k) Members shall use the Riders - Employee evidence of coverage for HMO Plan as set forth in the Appendix to this chapter as Exhibit AA, Part 1, "Card/Mail"; Part 2, "Card"; and Part 3, "Mail".]

(l)] All small group health benefits certificates and employee evidences of coverage issued to employees covered under small employer health benefits plans on and after January 1, 1994, shall be issued in accordance with these rules.

11:21-4.4 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, Members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board, through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix, incorporated herein by reference, subject to the following:

1. If expressly permitted by the Board, the Compliance and Variability Rider may be issued by Members to incorporate changes to the standard policy forms Plans A - E, HMO and HMO POS contracts, certificates, evidences of coverage, or standard riders promulgated by the Board. Nothing contained herein shall prevent a Member from issuing a standard policy form Plans A - E, HMO or HMO POS contract, certificate, evidence of coverage or standard rider which has incorporated board promulgated changes.

(b) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, members may make any changes to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board consistent with the variability as explained in Exhibit K [and JJ] to this Appendix through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix.

(c) Members may use the Compliance and Variability Rider only as permitted by 4.4(a) and (b) above. In no event shall the Compliance and Variability

Rider be used in lieu of optional benefit riders which riders are subject to the filing requirements set forth in N.J.A.C. 11:21-3.2(d).

11:21-6.3 Enrollment

(a) Small employer carriers shall require each eligible employee electing coverage under the small employer health benefits plan to complete either:

(1) the Enrollment form approved by the Board and specified in Exhibit Q of the Appendix to this chapter incorporated herein by reference, except that carriers can reformat the standard application in any manner necessary to simplify administration for the carrier without modification of the content of the form. At the end of the standard application in an additional section, a carrier may also require periodic updates of the following information: name changes, primary care physician change, health center changes, additions or deletions of family coverage, address changes and State and Federal continuation election[.]; or

(2) the enrollment form promulgated by the Department of Banking and Insurance set forth at N.J.A.C. 11:22-3.3 and Appendix Exhibit 1.

(b) Small employer carriers offering the HMO plan and the HMO POS plan shall require each eligible employee electing coverage under the HMO plan to complete either:

(1) the enrollment form approved by the Board and specified in Exhibit Q of the Appendix to this chapter incorporated herein by reference, except that carriers can reformat the standard application in any manner necessary to simplify administration for the carrier without modification of the content of the form. At the end of the standard application in an additional section, a carrier may also require periodic

updates of the following information: name changes, primary care physician change, health center change, additions or deletions to family coverage, address changes and State and Federal continuation election[.]; or

(2) the enrollment form promulgated by the Department of Banking and Insurance set forth at N.J.A.C. 11:22-3.3 and Appendix Exhibit 1.

(c) A small employer carrier may require a report of an eligible employee's health status for the purpose of determining the applicability of the preexisting condition limitation in accordance with the Act. The carrier shall require eligible employees to complete the Health Status form approved by the Board and specified as optional text in Exhibit Q of the Appendix to this chapter incorporated herein by reference.

1. Such report may be used only for the purpose of determining the applicability of a preexisting condition limitation in accordance with the Act.

_____ Date: January 4, 2002

Wardell Sanders, Executive Director